Summary of Florida's Medicaid Reform Waiver

Component	Description
Reform Authority	Section 1115(a)(1) Research and Demonstration Waiver
Reform Name	Florida Medicaid Reform
Time Frame	• Approved by CMS October 19, 2005. • 5-year period: July 1, 2006 – June 30 2011 • Phase I—July 1, 2006 Implementation in 2 Counties: Broward and Duvall. Within 1 year, expansion to 3 additional counties: Baker, Clay, Nassau. • Phase II—If legislature approves, based on experience in Phase I, expansion to additional geographic areas. • Phase III—Expansion statewide by June 2010.
Goals	• Patient Responsibility and Empowerment • Marketplace Decisions • Bridging Public and Private Coverage • Sustainable Growth Rate
Main Program Elements	• Risk-Adjusted Premiums • Enhanced Benefit Accounts (EBA) • Employer-Sponsored Insurance (ESI) • Low-Income Pool (LIP)
Quick Summary	• The State will develop risk-adjusted premiums for Medicaid enrollees. This caps the amount the state will spend on a beneficiary for any given year. • Health Plans will offer all mandated benefits, but can tailor their scope to meet the needs of specific Medicaid groups. • Beneficiaries can choose the plan that best meets their needs. By participating in activities that promote healthy behavior, beneficiaries earn credits which can be used to purchase additional services, such as over-the-counter drugs. • Beneficiaries can also choose to enroll in their employers' plan with the State contributing toward the cost of that plan up to the Medicaid premium amount.
Populations Covered (Initially)	<u>Mandatory Participants</u>: • TANF and TANF-related group--1931 Eligibles o Families under 23% of FPL o Poverty-related children with income above TANF limit: ▪ Up to age 1, up to 200% FPL ▪ Up to age 6, up to 133% FPL ▪ Up to age 21, up to 100% FPL (All are mandatory Medicaid eligibles except poverty level children up to age 1 with income between 185% and 200% of FPL) • Aged and Disabled—SSI cash assistance (75% of FPL) and children eligible under SSI.

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	Voluntary Participants: (Mandatory enrollment of these groups will be phased in) • Foster children • Individuals with developmental disabilities • Children with special health care needs • Individuals residing in institutions • Individuals in hospice-related group • Pregnant women above 1931 poverty level • Dual eligible individuals Enhanced Benefit Account • Individuals under 200% of FPL can continue to access EBA benefits after losing Medicaid eligibility.
Enrollment	• Newly Medicaid eligible will be enrolled upon becoming eligible • Current enrollees will enroll in reform plan at the time of eligibility re-determination or open enrollment period.
Service Providers	• The Health Plans can be Managed Care Organizations, Provider Service Networks, or Employer-Sponsored Plans.
Benefit Packages	• Benefits received determined by the group an individual is in, and by the Plan chosen. • Health Plans must cover all mandatory State Plan services. • For children under 21, pregnant women, and emergency services, service limits cannot be more restrictive than State Plan limits. • For other populations and services, plans can change the amount, duration and scope of State Plan services to tailor it to particular population, but revised benefit package must be actuarially equivalent to the current State Plan package and State must certify that it meets a benefit sufficiency standard. • Benefits divided into comprehensive and catastrophic benefit packages Comprehensive Benefits • Services which most people need. Represents dollar amount equivalent to 90% of historical Medicaid expenditures. • The premium covers 100% of the cost of care up to established comprehensive care threshold, then the catastrophic benefit premium covers additional care. Catastrophic Benefits • For unusually high costs incurred by an enrollee during a given year. Expected to represent less than 10% of the aggregate premium. • Catastrophic benefit threshold is triggered by either a pre-determined dollar threshold or an inpatient day threshold. • If MCO accepts financial risk, it receives catastrophic premium and pays for catastrophic care up to annual limit. If MCO does not accept risk, State becomes a re-insurer and pays MCO Medicaid fees for catastrophic level care. Enhanced Benefits Account (EBA) • For clients that participate in State-defined activities that promote healthy behavior, State deposits funds into an EBA account which can be used for additional services such as over the counter drugs or vitamins.

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	Employee Sponsored Insurance • Medicaid clients can voluntarily opt out of Medicaid coverage and enroll in their employer's health insurance plan. • State pays up to the amount it would have paid to cover recipient under Medicaid. (If ESI premium is higher, client pays the difference.) • State does not provide any wrap-around. (State does not pay difference between ESI cost sharing and nominal Medicaid cost sharing, nor does it cover services not covered under the ESI plan.)
Premiums	• State develops aggregate, risk-adjusted premiums based on individuals' age, sex health status. The Aggregate premium is divided into Comprehensive and Catastrophic Care components, based on pre-determined dollar amounts. The annual maximum benefit limit will be applied to all recipients with the exception of children under 21 and pregnant women. (Recipients are responsible for making arrangements for care which exceeds the annual benefit limit.)
Payment to Plans	• Risk-adjusted premiums are divided into comprehensive and catastrophic components. • All plans are at risk for comprehensive component and receive a premium for comprehensive care. Plans can choose whether to cover (be at risk for) catastrophic component. If plan chooses not to cover catastrophic component, the State becomes the re-insurer and plan remits claims to the State for services rendered under this component. • State has built-in safeguards to minimize cost shifting and maximize enrollee care.
Cost Sharing	• ESI participants will have to pay any cost sharing imposed by their employers' plans. All other enrollees will be subject to the same cost sharing restrictions and protections provided for all Medicaid recipients under federal law.
Other	• A Low Income Pool was established to ensure continued government support for provision of health care services to Medicaid, underinsured and uninsured populations. The Pool is a capped annual allotment of $1 billion per year for five years. •
Waivers Requested	• Statewideness/Uniformity—(Different delivery systems in certain areas) • Amount, Duration, and Scope and Comparability—(Different intensity of services for mandatory services, and different benefits for those in ESI or EBA groups) • Income and Resource Test—(Greater income/resource limits for EBA group) • Cost Sharing—(Greater cost sharing limits for ESI group) • Freedom of Choice—(Of providers) • Provider Agreements—(Allows non-enrolled providers to provide benefits to EBA group) • Retroacitve Eligibility—(Waives 3-month retroactive eligibility) • Eligibility—(Provide only emergency are and nursing home care for up to 30 days from eligibility date until enrollment into MCO. Also allows for ESI group to receive less than State Plan benefits).

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	• Payment Review—(To extent that prepayment review may not be available by individual beneficiaries to their providers.)